

LAST NAME _____ FIRST NAME _____
DOB _____ DEPARTMENT _____
DATE _____

REQUIRED IMMUNIZATIONS – LIST DATES OF ADMINISTRATION

1. **Tetanus/diphtheria** _____
(one dose within the past 10 years)

2. **Measles (rubeola) vaccine:** #1 _____
(2 are required if born after January 1, 1957) or #2 _____
rubeola disease (documented by health care provider) or
positive rubeola titer (attach lab report) _____

3. **Mumps** vaccine or _____
mumps disease (documented by health care provider) or _____
positive mumps titer (attach lab report)

4. **Rubella** vaccine or _____
positive rubella titer (attach lab report)

5. **Hepatitis B** vaccine series (3 injections) or #1 _____
#2 _____
#3 _____
positive hepatitis B surface antibody titer (attach lab report) _____

***Hepatitis B vaccine is required if student will have patient contact and/or contact with human blood or body fluids*

6. **Varicella** vaccine series (2 injections) or #1 _____
#2 _____
Positive history of chicken pox disease or
positive varicella titer (attach lab report) _____

7. **Tuberculin skin test (PPD)** (required within the last 12 months, even if you have previously received BCG vaccine)

Date: _____ Result: _____negative _____positive (measurement in _____mm if available)

If positive, did you take isoniazid (INH) prophylaxis? _____Yes _____No

Chest x-ray findings if PPD is positive (**attach x-ray report**)

Date of chest x-ray: _____ Result: () No evidence of active tuberculosis
() X-ray consistent with active tuberculosis
() Abnormal x-ray, but not due to tuberculosis

Health Care Provider Signature

Address City State Zip Code

Phone Number Fax Number